Health Reimbursement Arrangement (HRA) Premium Reimbursement

(Do not Fax or Mail this Instruction Page)

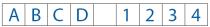


This form is used to request reimbursement for health care premium expenses only.

Submit your claim using this form.

Step 1: Complete the form

• Please print in capital letters, with the letters centered in the boxes as shown:



Complete a separate line for each individual expense.

Step 2: Attach Supporting Documentation

- See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable
- Do not send original receipts or original supporting documentation
- Photocopy your receipts and /or other supporting documentation onto a white, letter-sized sheet of paper

Step 3: Certify

Read the Certification and then sign and date the form

Step 4: Submit

- **FAX** the form and supporting documentation to 813-387-0737
- Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.
- Do not fax this instruction page or your own fax cover-sheet
- Alternatively, you may also mail your claims to:

Spending Account Processing PO Box 25172 Lehigh Valley, PA 18002-5172

Remember

Keep a copy of the form and all original receipts for your records

Direct Deposit!

Why wait for a check? Expedite your payments by signing up for direct deposit today at www.bsa.selectquotebenefits.com. (Go to the HRA link on the top of the page.)

NOTE: Once your banking information has been entered it may take up to 10 days to verify with your bank. During this time any payments will be sent via check until your banking information has been successfully validated.

If you have any questions about your account status, please create a Help Ticket at www.bsa.selectquotebenefits.com (HRA tab) 24 hours a day, 7 days a week, or reach the Acclaris Reimbursement Center toll-free at 866-479-8317 (Option 2) Monday - Friday during regular business hours.

Type of Supporting Documentation

- Copy of your premium invoice
- Must show:
 - Date of service or purchase
 - Amount (paid by you)
 - Name of person or organization providing the service or product
- Cancelled checks or credit card receipts are acceptable evidence

Please Do

- For multiple expenses on one receipt, use one line to show a total of such expenses
- For different expense types, or expenses that are on different receipts, use one line per expense/receipt
- Use additional copies of Page 2 if your expenses exceed the number of lines available
- Be sure to print legibly, use ink or type, and use capital letters

Please Do Not

- Fill out the form using red or blue ink
- Highlight receipts or any part of the form
- Send original receipts
- Photocopy the form
- Staple copied receipts to the form
- Write outside the boxes provided
- Submit the same claim more than once
- Fax or mail this Instruction Page

Health Reimbursement Arrangement (HRA) Premium Reimbursement

FAX TO: 813.387.0737

or Mail to: Spending Account Processing, PO Box 25172, Lehigh Valley, PA 18002-5172

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)		
PARTICIPANT ID / SSN	EMPLOYER or GROUP NAME	
PARTICIPANT LAST NAME	PARTICIPAN	NT FIRST NAME
PARTICIPANT EMAIL	DAY	TIME PHONE # (AREA CODE FIRST - NO DASHES)
PREMIUM REIMBURSEMEN PREMIUM	DATES OF SERVICE	
PREMIUMS PAID TO	FROM (MMDDYY)	TO (MMDDYY)
CHECK BOX IF FREQUENCY: MONTHLY, RECURRING QUARTERLY, ANNUAL OR ONE-TIME	PREMIUM PAYMENT AMOUNT	COVERAGE FOR (NAME & RELATIONSHIP)
	\$	
PREMIUM PREMIUMS PAID TO	DATES OF SERVICE FROM (MMDDYY)	TO (MMDDYY)
CHECK BOX IF FREQUENCY: MONTHLY,	PREMIUM PAYMENT AMOUNT	COVERAGE FOR (NAME & RELATIONSHIP)
RECURRING QUARTERLY, ANNUAL OR ONE-TIME		SOVERNOE FOR (IV WILL & REE/HONGHIII)
	\$	
PREMIUM PREMIUMS PAID TO	DATES OF SERVICE FROM (MMDDYY)	TO (MMDDYY)
CHECK BOX IF FREQUENCY: MONTHLY,		
RECURRING QUARTERLY, ANNUAL OR ONE-TIME	PREMIUM PAYMENT AMOUNT	COVERAGE FOR (NAME & RELATIONSHIP)
	J \$	
SECTION 3: SELF CERTIFICATION		
I certify that all expenses for which reimbur		y submission of this form have been or will b
		e expenses have not been reimbursed or are no nitted, I understand that it is my responsibilit
to notify the Administrator of any changes t	o my expenses, like a change in in	nsurance coverage or a change in premium, to that I alone am responsible for the sufficiency
accuracy and truthfulness of all information		

PARTICIPANT SIGNATURE:* _____ DATE: _____

of the program and have read the information on this form. Annual certification will be required.

including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms